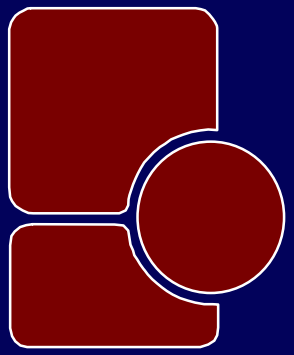
Joint Legislative Audit and Review Commission
of the Virginia General Assembly



Virginia's Medicaid Reimbursement to Nursing Facilities

Staff Briefing
December 13, 1999

Introduction

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Presentation Outline

- ☑ **Introduction and Summary of Findings**
- ☐ **Overview of Virginia's Medicaid Nursing Facility Reimbursement System**
- ☐ **Assessment of Virginia's Nursing Facility Reimbursement Methodology**
- ☐ **Nursing Facilities' Costs, Medicaid Payment Rates, and Quality of Care**
- ☐ **Options for New Reimbursement System and Funding**

Study Mandate

- SJR 463 (1999) directs JLARC to examine the Virginia Medicaid program's methodology for determining nursing facility reimbursement.
- This evaluation is to include:
  - a comparison of Virginia's approach to nursing facility reimbursement with the approach of other states;
  - the adequacy of reimbursement levels for providing quality of care;
  - options for simplifying the nursing facility reimbursement process; and
  - the extent to which patient acuity levels are factored into the current and proposed reimbursement approaches.

Research Activities

- Structured interviews with key State staff from the Department of Medical Assistance Services (DMAS) and the Department of Health (VDH), as well as staff from the nursing facility provider associations
- Monitoring of meetings between DMAS and nursing facility provider representatives at which DMAS proposals for changing the reimbursement system were discussed.
- Survey of nursing facility administrators
- Analysis of data from DMAS and VDH on nursing facility provider costs, Medicaid payment, and quality of care
- Review of various state, federal, and other documents on nursing facility reimbursement and quality of care

Summary of Findings

- The State has controlled Medicaid reimbursements to nursing facilities over the years by utilizing nationally-recognized procedures that promote efficiency.
- However, a review of DMAS' reimbursement methodology also indicates that certain components are outdated and appear to be excessively restrictive.
- One of the impacts of restricting the Medicaid reimbursements is that private pay residents appear to subsidize some of the costs of Medicaid residents.

Summary of Findings
(continued)

- The factors that relate to controlling costs are not the same as those that promote quality of care. For example, higher quality of care tends to be provided in facilities that are small in size and in non-profit facilities; lower-cost care tends to be provided in facilities that are large in size and in for-profit facilities.

- However, the evidence on the association of costs and quality is mixed. DMAS should review management and operational practices of facilities that have both low costs and high quality of care to obtain additional value for the dollars spent.

Summary of Findings
(continued)

- While a certain amount of complexity is inherent in a Medicaid reimbursement methodology, some approaches to achieve the goal of greater simplicity are discussed in the report.

- JLARC staff options indicate a range from $1.7 to $31.8 million in additional annual funding that could be provided to nursing facilities to address shortcomings in the current reimbursement approach. (This range is less than the $104 million currently being requested by the nursing facilities.)

Summary of Findings
(continued)

- However, the JLARC staff funding options would be in addition to the $21.7 million annual increase appropriated during the 1999 Session. Over two years, the increase could range from $23.4 to $53.5 million (about half federal costs, half State).

- Also, if the State routinely rebases its costs, as is recommended, then as the facilities expend more to pay for quality care, the proposed reimbursement methodology will recognize a higher cost level.

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Background

- Four out of every ten people turning 65 will use a nursing home at some point in their lives.
- The nursing home population is projected to increase 50 percent between 1990 and 2010 and double by 2030.
- Nationally, Medicaid is the primary source of public financing for long-term care, financing almost 70 percent of all nursing home beds.

Background
(continued)

- Virginia's Medicaid budget for FY 1998 was $2.3 billion, of which about $410 million was for Medicaid payments to nursing facilities for care provided 27,683 Medicaid residents at an average cost of $14,800 per resident.

- Clearly, one of the most important issues in the nursing home industry today is financing. Virginia's nursing facilities claim they can no longer subsidize low Medicaid reimbursement rates. Owners of ten Virginia nursing facilities declared bankruptcies within the last six months; low Medicaid reimbursement was one of the reasons cited.

- The study mandate reflected legislative concern that Medicaid reimbursement to nursing facilities may not be adequate to promote quality care.

Virginia's Medicaid Nursing Facility Reimbursement System

- Virginia's current Medicaid nursing facility reimbursement system consists of two separate payment methodologies: one for the general Medicaid nursing facility population, and a separate one for specialized care residents (those residents whose care needs are medically complex and require extensive nursing facility resources).

- Both systems pay nursing facilities prospectively. Medicaid rates are set in advance but based on historical cost data that has been projected forward to meet expenditures for the upcoming year.

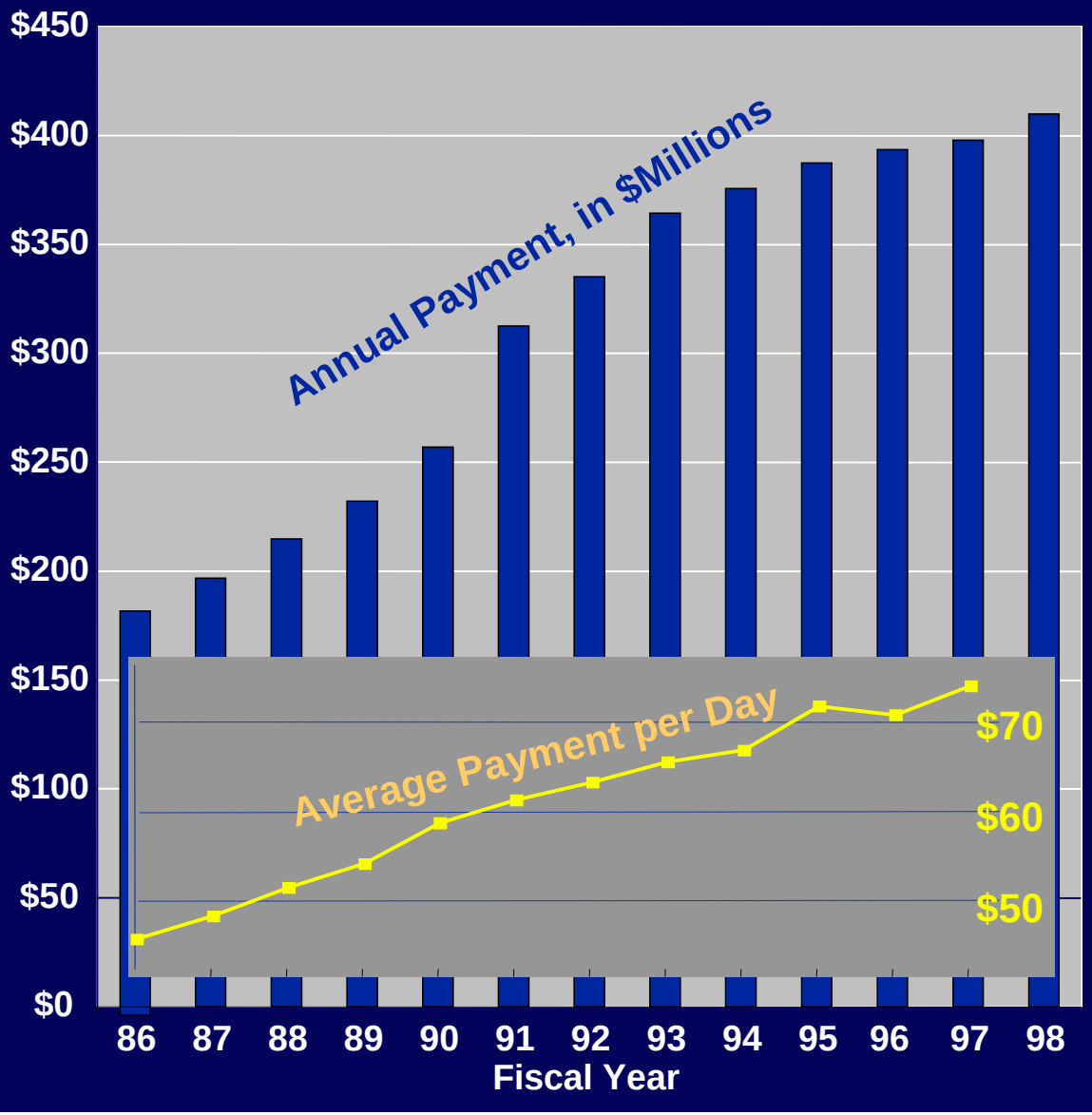
Key Components of Virginia's Payment System

- Virginia's payment system has three cost components:
  - Direct patient care costs, including nursing staff salaries and therapy costs (payment levels are established for three peer groups). These costs are more closely related to quality of care and are adjusted by a case mix factor to account for differences in the care needs of Medicaid residents.
  - Indirect patient care costs, including dietary, laundry, and housekeeping services (payment levels are established for eight peer groups)
  - Plant or capital costs, including depreciation, building renovations, and equipment.

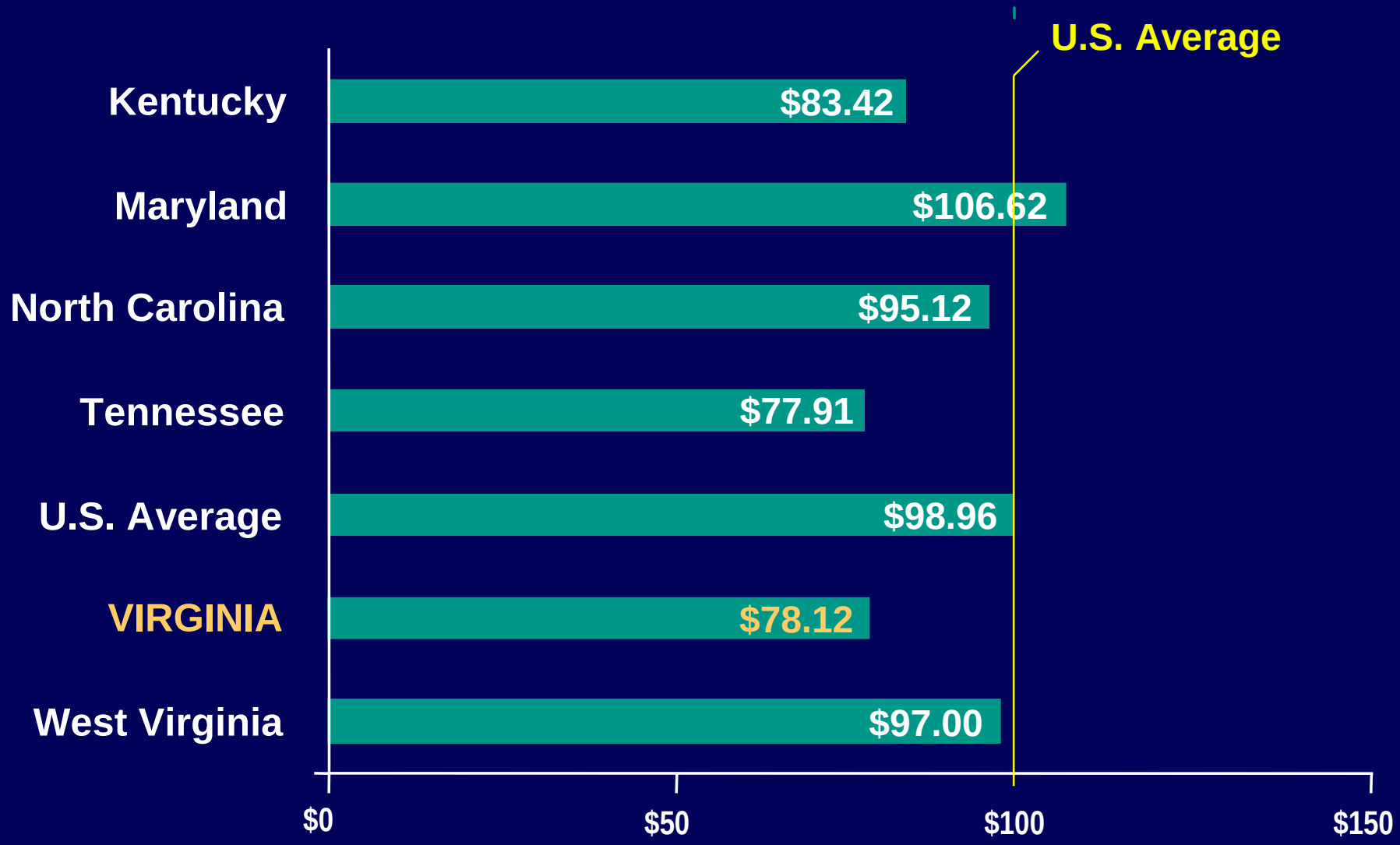
Methods Used in Virginia's System that Have Controlled Costs

- Virginia has utilized three methods which have the impact of controlling nursing facility costs:
  - Sets upper payment limits or ceilings for the direct and indirect care cost categories, which are based on median costs of facility peer groups (divides the facilities within each peer group into half based on unit costs, and use the median cost for the payment ceiling).
  - Provides an efficiency incentive as a reward for controlling costs below the payment ceiling.
  - Utilizes a 95 percent occupancy standard by reducing reimbursement to facilities that do not meet this level.
- In addition, infrequent reevaluation of nursing facility cost data to determine whether payment ceilings require adjustments has had a cost control impact.

Average Annual Rate of Increase in Reimbursements to Nursing Facilities Was 3.1 Percent from FY 1991 to FY1998



Comparison with Other States Suggests that Virginia's Payments Are Relatively Low

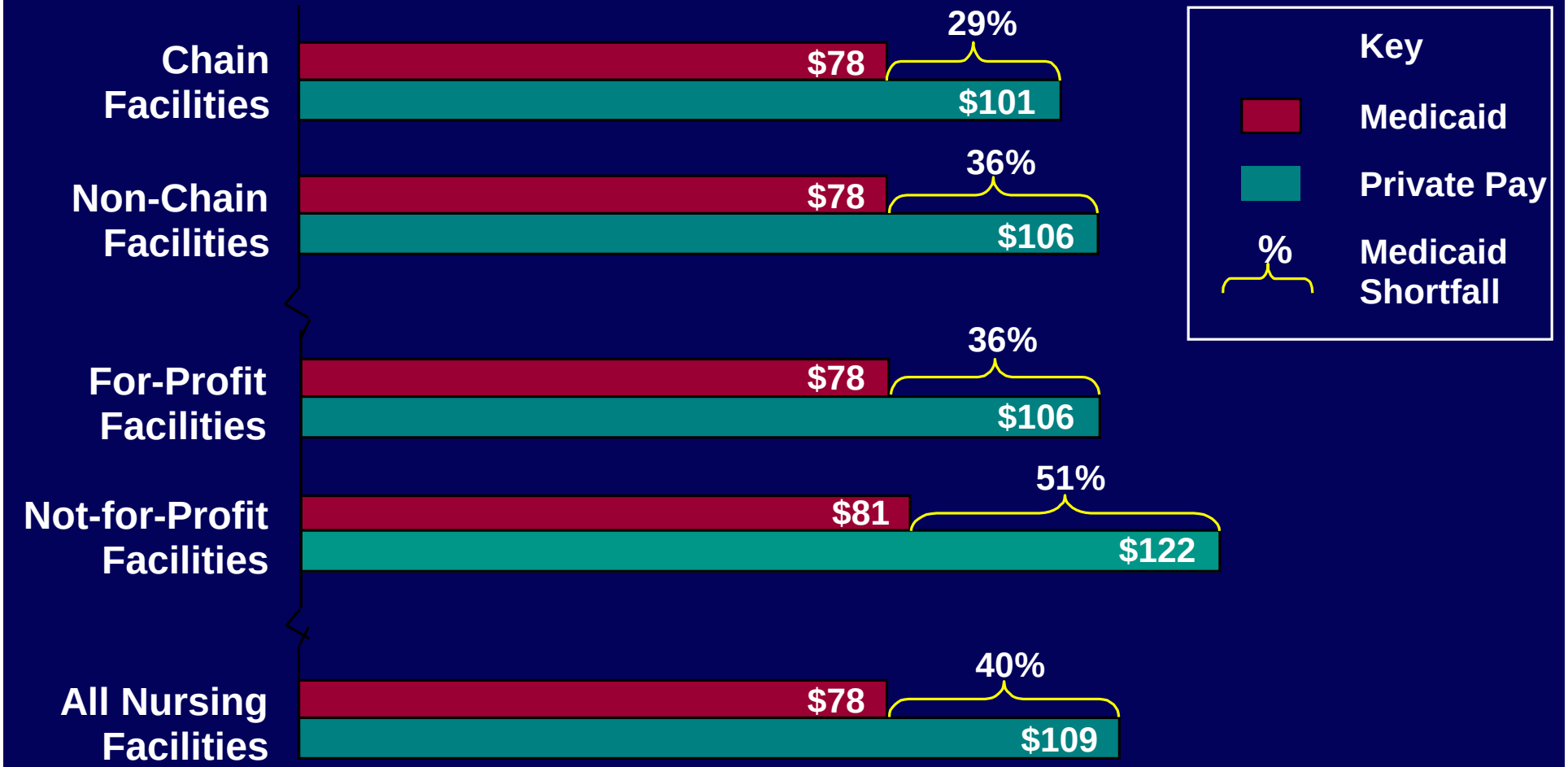


Bringing Virginia's Per Diem Rate Up to the National Median Would Not Be the Best Method for Ensuring Adequate Payment

- At the present time, Virginia's 1998 per diem payment of $78.12 is ranked 40th in the nation for nursing facility reimbursement.
- This ranking process is misleading because of the variation of what states include in their reimbursement rates.
  - JLARC staff made adjustments to DMAS' per diem rate to include some costs that other states may include, which brought the per diem rate up to $80.52 and a ranking of 38th. However, similar adjustments could not be made to other states.
  - To bring Virginia up to the national median would cost approximately $95 million in FY 2001 dollars.

Private Pay Residents Appear to Subsidize Medicaid Payment Rates

1997 Per Diem Rates for Nursing Facilities in Virginia



Virginia's Nursing Facilities Care for Medicaid Residents Who Have Higher Care Needs Than the National Average

- Virginia is ranked number one in the country for having the heaviest care nursing facility residents based on the need for staff assistance with self-care tasks or Activities of Daily Living (dependent in 4.25 ADLs compared to the national average of 3.67 ADLs).
- Two reasons for this may be the stringent nursing facility pre-admission screening criteria that are used and the availability of community-based care alternatives.
- Virginia's Medicaid nursing facility residents' care needs have slowly increased over time. Since 1991, care needs (as measured by ADLs and other special conditions) have increased eight percent.

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Virginia's Upper Payment Ceilings Have Not Been Adjusted in Over Nine Years

- For nursing facilities operating costs (direct patient care and indirect care costs), the Medicaid program pays the lower of the facilities' costs or the upper payment ceiling (set at the median) established for certain peer groups.

- These upper payment ceilings have only been inflated forward over the last nine years, but have not been adjusted to reflect the costs incurred by the facilities.

Direct Care Operating Ceilings Are Now Well Below the Median Facility Costs

- The consequence of not recalculating the medians since 1990 is that over 60 percent (rather than 50 percent) of the facilities have been over their peer group upper payment ceiling for direct care since at least 1994.

- Based on 1997 cost data, 151 of 239 (63 percent) nursing facilities were not reimbursed for direct care costs of $23.8 million because they were over the payment ceiling. Individual facilities were not reimbursed for allowable costs ranging from $1,117 to $720,547.

Indirect Care Costs Have Been Funded More Generously

- On the other hand, DMAS has also not adjusted indirect care costs to reflect the median costs.
- The result is that in 1997, one out of three nursing facilities costs are below the upper payment ceiling for indirect care costs. These facilities could have spent an additional $23 million in this cost category.
- If DMAS had adjusted the direct and indirect care ceilings, more funds could have been shifted to cover nursing staff costs.

Other States Used for Comparison Purposes Allow for Payments Above the Median for Direct Care Costs

- It should be noted that even if DMAS updated the median peer groups values, the use of medians to set the upper payment ceilings for operating costs, especially for direct care costs, may be overly restrictive.

- Most states set their upper payment ceilings at some percentage over the median or at a higher percentile which more accurately reflects legitimate variations in costs and the diversity of resident care needs. Several states recognize costs between 115 to 125 percent of the median costs.

Recommendations

- The General Assembly may wish to direct DMAS, in the design of the new nursing facility reimbursement system, to set the upper payment ceilings for direct care operating costs at a certain percentage over the median costs of providing care in order to better address the costs associated with caring for a diverse population.

- The General Assembly may wish to direct DMAS to review nursing facility cost data annually in order to adjust the upper payment ceilings for direct and indirect care operating costs.

Occupancy Rate Standard Has Not Been Adjusted to Meet Trend Changes in Long-Term Care

- Occupancy rates are calculated as the average daily census of facility residents compared to the total number of beds and expressed as a percentage. Higher occupancy rates are expected to result in less costs per patient day.

- DMAS utilizes a 95 percent occupancy standard for all but five facilities on all three cost components (direct care, indirect care, and plant). This means that facilities are reimbursed less if they do not meet this standard. This standard is higher than that used by most states examined for comparison purposes.

Occupancy Standard Should Be Reduced and Removed from Direct Care Costs

- The 1998 statewide occupancy rate was 91 percent and appears likely to decline further due to the rapid development of assisted living.
- This trend should not be slowed as care in an assisted living arrangement is generally less expensive than nursing facility care. However, facilities should not be held accountable to a 95 percent rate, especially on direct care costs.

Recommendation

- The General Assembly may wish to direct DMAS to reduce the occupancy standard that is applied to indirect care and plant costs to 90 percent to reflect the trend in declining statewide occupancy rates. In addition, DMAS should remove this cost containment strategy on the costs most directly related to patient care. DMAS should review this standard every two years to determine whether further reductions are needed based on statewide occupancy trends.

Most Nursing Facilities Do Not Receive an Adequate Adjustment to their Medicaid Rate for Case Mix

- Case mix adjustments to the direct care portion of the Medicaid rate are made to improve access for patients with heavy care needs, enhance quality of care, and to reimburse facilities based on the care needs of the residents.
- Virginia's current case mix system, known as the Patient Intensity Rating System or PIRS, is outdated and needs replacement.
- In addition, the current payment methodology for utilizing case mix in determining the Medicaid rate reduces payments across all facilities by $1.4 million.

Recommendation

- The General Assembly may wish to direct the Department of Medical Assistance Services to implement the federal case mix system, known at Resource Utilization Groups (RUGS-III), for linking payment to the care needs of all nursing facility residents, including the specialized care residents. In addition, DMAS should ensure that the methodology and calculations that use the case mix scores do not reduce the funding that is available system-wide.

For Many Facilities, Inflation and Case Mix Factors Are Negated by the Current Upper Payment Limit for Direct Care Costs

Part A: Direct Patient Care Costs

Allowable costs / Medicaid adjusted patient days → (Cost per day) X (Inflation factor) X (Case mix trend factor) = Adjusted direct patient care cost per day

$1,783,901 / 48,304 → ($36.93) X (1.0399) X (1.01613) = Rate A $39.02

Part B: Direct Patient Care Upper Payment Limit

(Peer group ceiling) X (Facility case mix factor) = Adjusted direct patient care ceiling

($33.34) X (.8754) = Rate B $29.19

Medicaid Reimbursement Methodology Comparison
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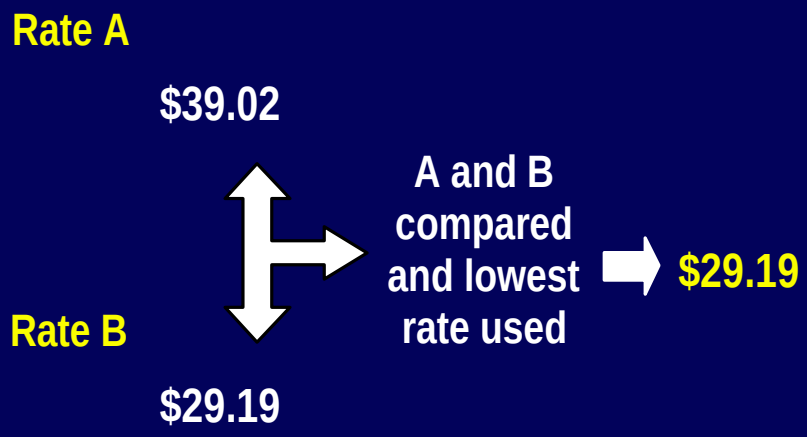
Medicaid Reimbursement Rate



Lost Reimbursement

	$39.02	Rate A
–	$29.19	Rate B
	$9.83	Per Medicaid patient day
X	45,149	Medicaid unadjusted patient days
	$443,815	Loss for year

Recommendation

- The General Assembly may wish to direct DMAS to apply the case mix adjustments to the upper payment ceilings for direct care only and to utilize the most current facility case mix scores.

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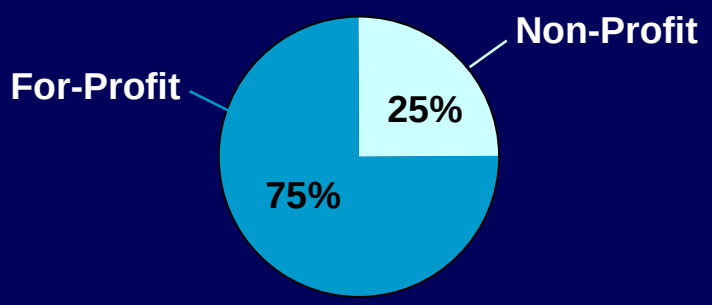
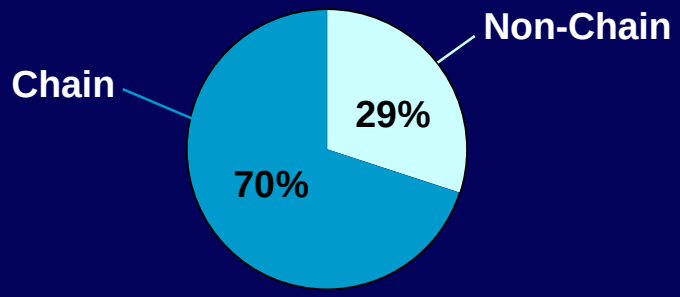
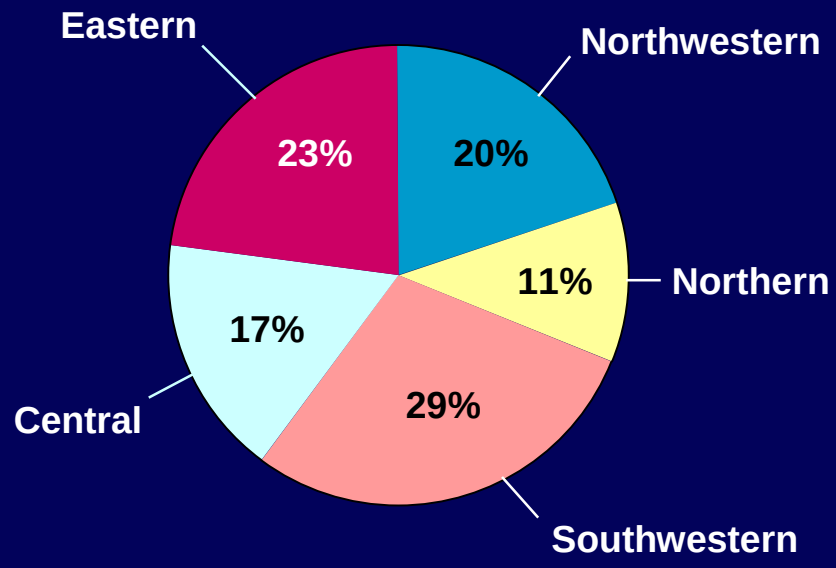
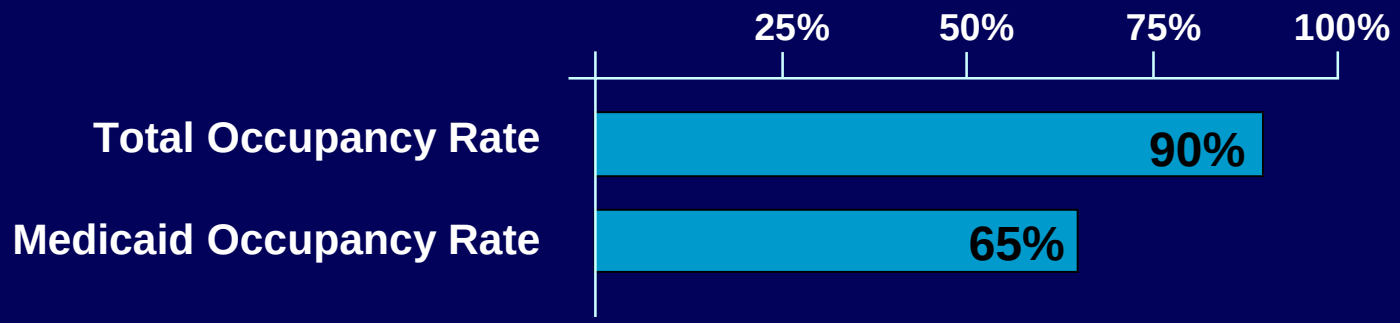
Nursing Facilities Are a Diverse Group

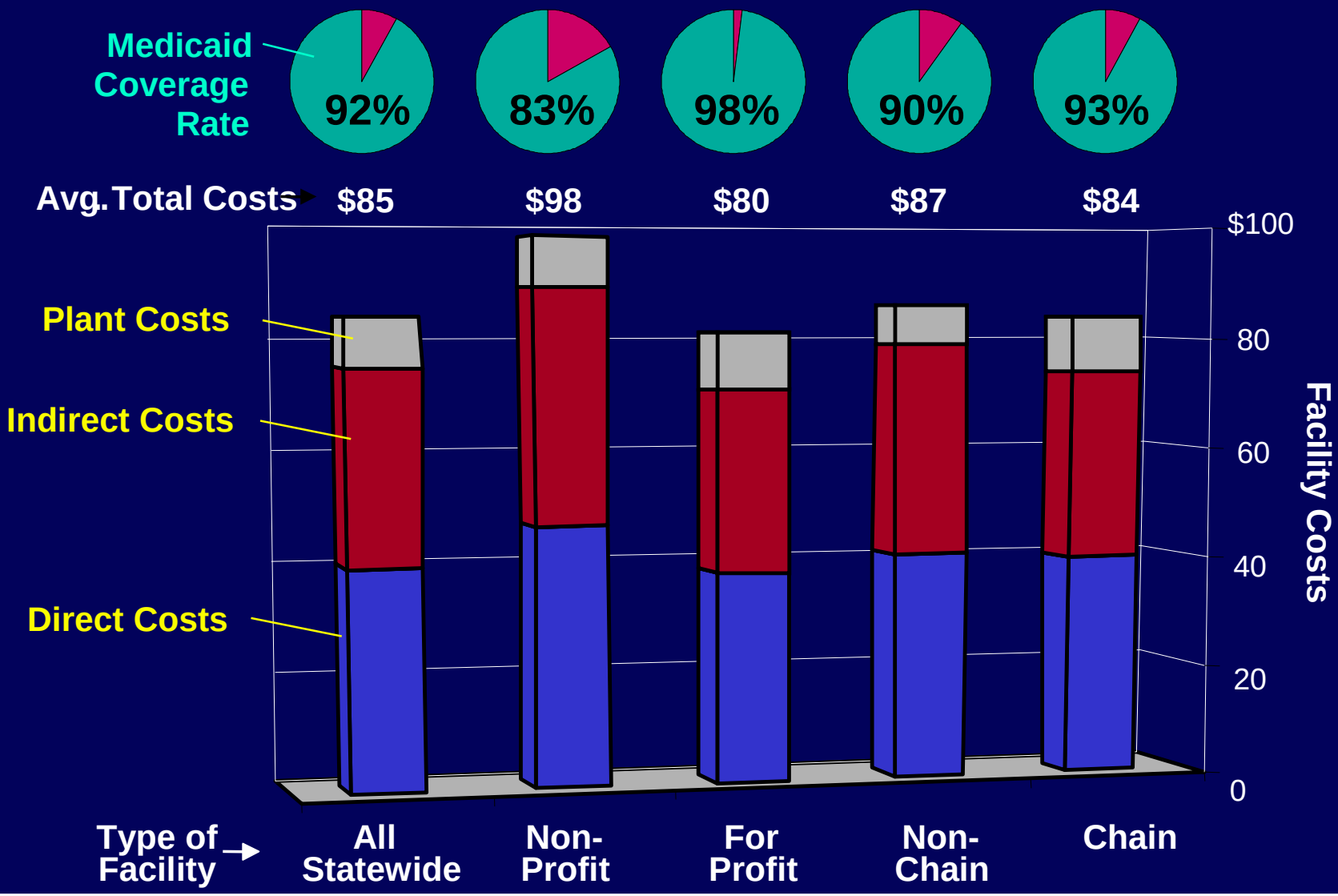








Nursing Facilities' Costs Exceed Medicaid Payment

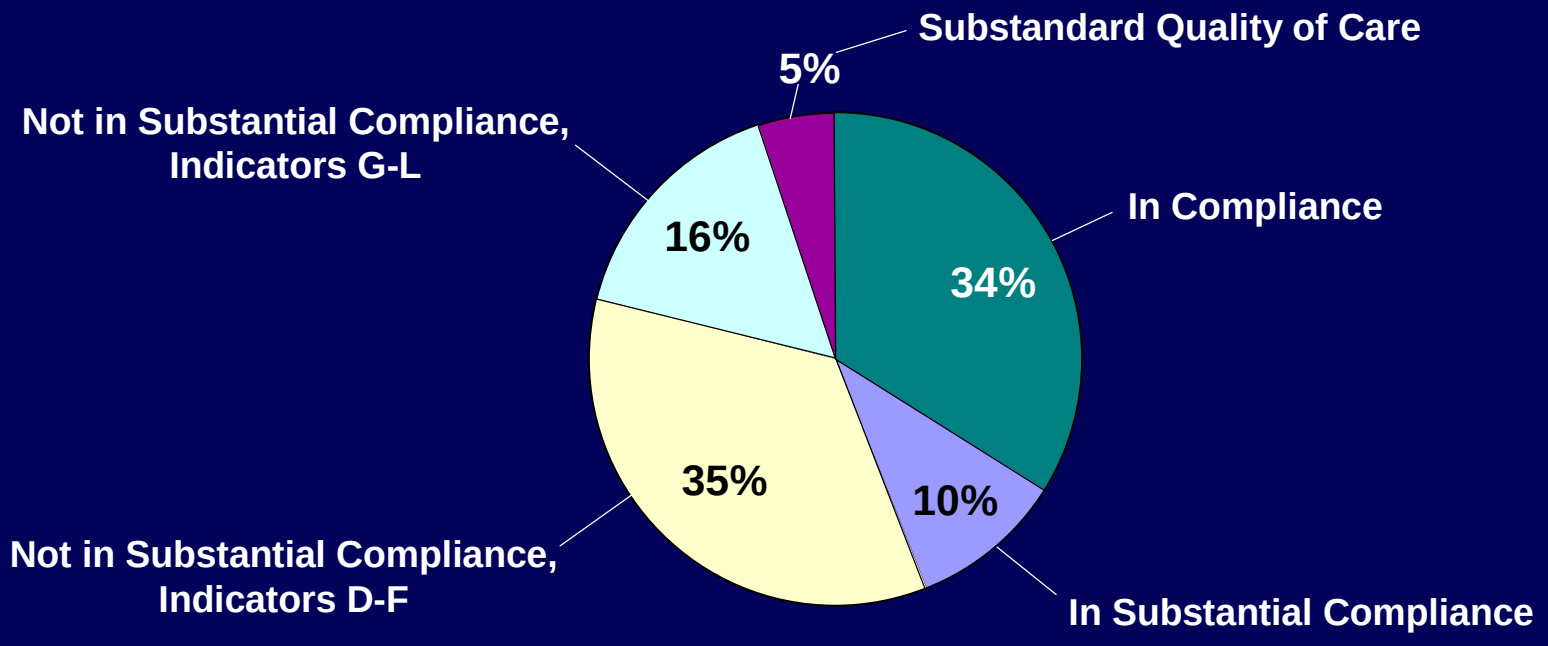


Large, For-Profit Nursing Facilities Provide the Lowest Cost Care

Facilities Who Are More Likely to Have the Highest Total Costs	Facilities Who Are More Likely to Have the Lowest Total Costs
• Non-Profit facilities	• For-profit facilities
• Facilities with 1-60 beds	• Facilities with more than 120 beds
• Facilities located in northern Virginia	• Facilities located in southwestern and eastern Virginia
• Facilities that care for less Medicaid residents	• Facilities that care for more Medicaid residents

While Few Virginia Nursing Facilities Provide Substandard Care, More Than Half Have Difficulty Meeting Federal Standards

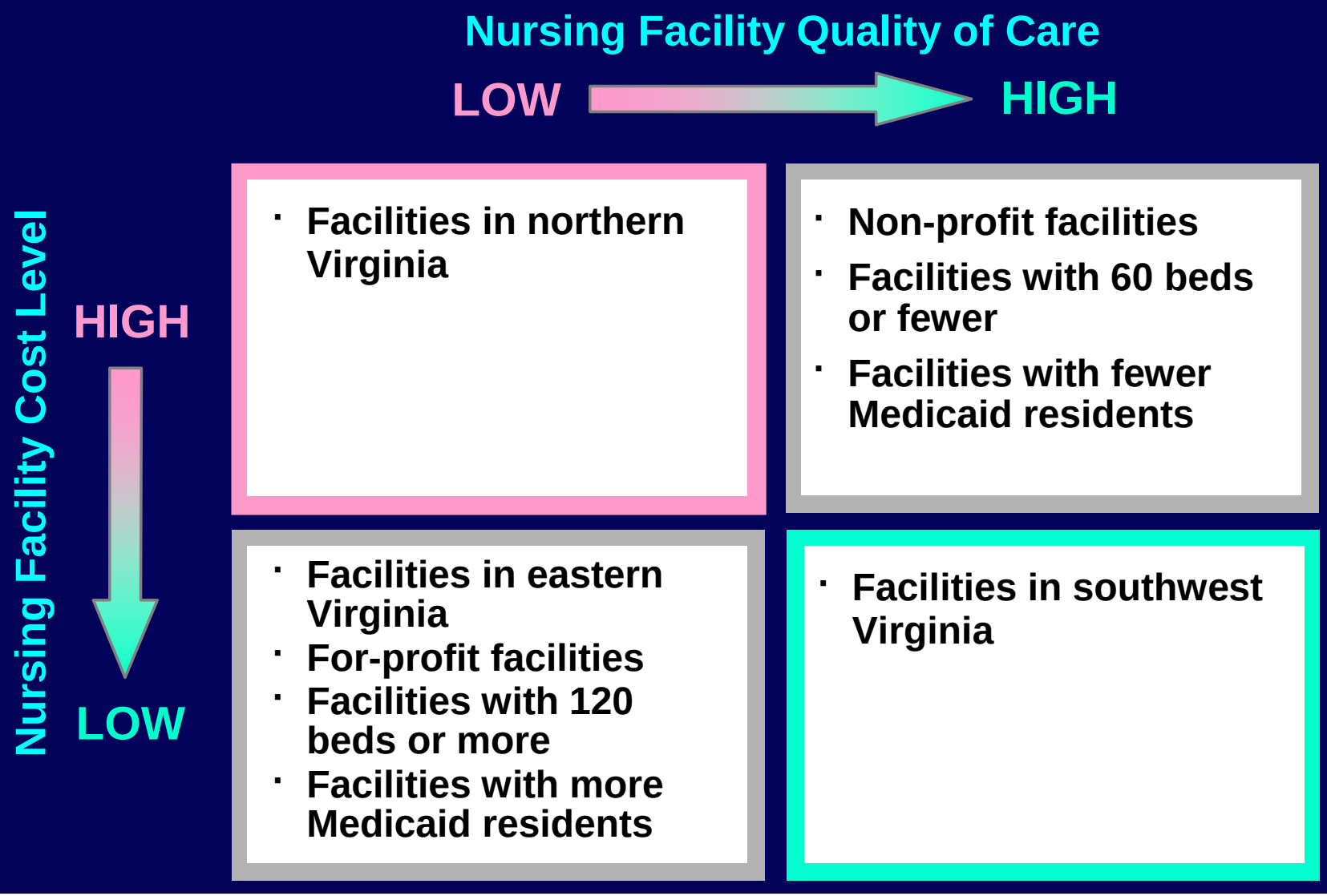
Virginia Nursing Facility Medicare and Medicaid Licensure and Certification Survey Results For Calendar Year 1997



Some High Quality Nursing Facilities Have Low Costs, but in General, There Appears to Be an Association Between Costs and Quality

Nursing Facility Costs And Medicaid Rates	In Compliance	In Substantial Compliance	Not in Substantial Compliance		Substandard Care
			Indicators D-F	Indicators G-L	
Total Costs	$83	$95	$89	$79	$74
Direct Operating Costs	39	47	41	38	36
Indirect Operating Costs	34	38	38	32	30
Plant Costs	10	10	10	8	8
	N=71	N=17	N=86	N=40	N=12

Factors Related to Controlling Facility Costs Differ from Factors that Promote Quality



Exceptional Nursing Facilities Should Be Reviewed for "Best Practices"

- While the data show an association in costs and quality for facilities below a certain quality tier, many of Virginia's highest performing facilities also have relatively low costs.
- An examination of these 71 low-cost facilities found:
  - A majority of these facilities (55 percent) had no deficiencies in annual surveys for at least two of the last three years, and 18 percent had no deficiencies in all three years.
  - Some of the reasons for the relatively low costs at these facilities are not replicable at all facilities (for example, many high-quality, low cost facilities are in southwest Virginia).
  - However, in-depth examination of these facilities may reveal some management and operational factors that contribute to high-quality at low cost and that could be replicated elsewhere.

Recommendation

- The Department of Medical Assistance Services, in cooperation with the Department of Health and the nursing facility providers, should examine the management and operational practices of the nursing facilities that consistently perform well on the nursing facility survey to identify and disseminate information about best practices to the other nursing facilities.

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DMAS Has Been Meeting with Providers to Develop a New Reimbursement System

- Over the past seven months, DMAS has conducted a series of meetings with the nursing facility providers on the development of a new Medicaid nursing facility reimbursement system. JLARC staff monitored these activities.

- During the course of the meetings, DMAS staff articulated a view that "DMAS does not expect to pay out more" under the new reimbursement system than under the current system.

Budget Neutrality Stalled Development of a New System

- Representatives from the nursing facility industry expressed the view that the current system is inadequately funded, and a new system that divides up these same funds in a different manner is not acceptable.
- This funding issue stalled development of a new reimbursement system during the late summer and early fall of 1999.
- In October 1999, the nursing facility provider associations brought options to DMAS' attention for moving forward with the process if DMAS would support the appropriation of sufficient funding to allow the new system to work.

DMAS' Current Position for Funding the Reimbursement System

- In late November 1999, DMAS responded to the providers by stating that it can only assume current funding levels at this time, but it is willing to delay development of the regulations until the close of the 2000 Session.

- It appears that DMAS will not make a recommendation or take a position on which cost-controlling mechanisms it is willing to make less restrictive unless and until funding is approved at the General Assembly Session.

JLARC Staff Assessment of DMAS' Proposed Changes to the Reimbursement System

- Overall, JLARC staff have found that the position of revenue neutrality is probably unreasonable. The State's current methodology unduly restricts direct care costs, which is counterproductive to quality of care.

- This report presents several options that DMAS has developed for the new reimbursement system, the nursing facility's position on these options, and JLARC staff evaluation of these options.

Balancing the Need to Control Costs With the Need to Provide Adequate Reimbursement for Quality of Care

- State-level policy makers have struggled for years with how to control the growth in Medicaid expenditures while providing an appropriate level of reimbursement.
- In Virginia, from 1991 through 1998, many actions were taken to increase and decrease nursing facility payments, based on various considerations.
- However, in 1999, payments were increased by $21.7 million annually for nursing staff salaries.

Options Are Available to Improve Quality of Care

- The study mandate required JLARC staff to consider the "adequacy of reimbursement levels for providing quality of care". JLARC staff addressed this requirement through recommendations and funding options about removing restrictive standards from the reimbursement methodology on the direct care cost components. Direct care costs are the costs associated with nursing staff levels and salaries, and impact quality of care.

- The development of quality of care incentives may also help improve the quality of care in facilities.

Options Are Available for Simplifying the New Reimbursement System

- While a certain amount of complexity is inherent in a Medicaid reimbursement methodology, some approaches to achieve the goal of greater simplicity are discussed in the report, including:
  - Have a single payment system that includes specialized care residents
  - Move indirect care costs to a system based on a set price which reduces some cost settlement activities
  - Eliminate some other tasks related to cost settlement
- DMAS should develop a long-range plan to develop a payment system similar to the Medicare system to further simplify the methodology.

Funding Options from $1.7 to $31.8 Million Are Necessary to Reimburse Direct Care Costs that Promote Quality

- Funding Option 1: Restore funding for the negative impact in funding of the case mix adjustment. Cost is projected at $1.7 million for FY 2001 (about half of this amount would be State, about half federal)

- Funding Option 2: In addition to restoring the funding for case mix loss, reduce the occupancy standard to 90 or 93 percent for all cost components, and/or eliminate the standard from direct care costs. These options can range from $3.0 to $5.3 million (about half of this amount would be State, about half federal).

Funding Options
(continued)

- **Funding Option 3: In addition to restoring the funding for case mix loss, adjust the current upper payment ceilings for direct care to the median or 105 to 125 percent over the median. These options can range from $8.7 to $24.6 million (about half of this amount would be State, about half federal).**

- **Funding Option 4: This last option is based on a combination of the three options. It restores the funding for case mix loss, reduces the occupancy standard to 90 percent for indirect and capital costs, removes the occupancy from direct care costs entirely, and adjusts the direct care upper payment ceilings to the median or from 105 to 125 percent over the median.**

Combined Funding Increases from 1999 and 2000 Sessions Could Range from $23.4 to $52.1 Million

- The funding requirements for Option 4 range from $15.5 to $31.8 million (about half of this amount would be State, about half federal).
- In combination with the $21.7 million increase from the 1999 Session, total annual funding to the nursing facilities would increase by $23.4 to $53.5 million.
- The nursing facilities funding request for similar adjustments as the JLARC staff options were approximately $78.8 million. Funding requests not addressed by the JLARC staff analysis were for an additional $25.8 million.

Future Funding Increases May Be Needed if Nursing Facilities Increase Direct Care Costs

- The JLARC staff funding estimates were based on spending patterns of nursing facilities in 1997 and trended forward to 2001.
- However, JLARC staff found that the spending patterns for for-profit facilities may be low because they appear to base their spending on their expected rate of reimbursement from Medicaid. If Medicaid payment is increased in the direct care area, it is likely that nursing facilities would also increase spending in this area.

Future Funding Increase May Be Needed

- In the future, if nursing facilities spend more in direct care costs, such as to hire more staff, increase wages of nursing staff, or to fill vacancies, some of these costs will be recouped over time through the submission of cost reports and the frequent recalculation of upper payment ceilings based on all facility costs. This will address some of the funding discrepancy between the JLARC staff analysis and the nursing facilities' much higher request for funds.

Recommendation

- The General Assembly may wish to consider the funding options for increasing the level of Medicaid reimbursement. Combined federal and State costs for these options range from $1.7 to $31.8 million. The costs of these options are in addition to the $21.7 million annual increase that was appropriated in 1999.